Detroit Area Agency On Aging

MI DETROIT

Stakeholders' Meeting

June 16, 2005
9:30 a.m. to 12:30 p.m.
Historic Trinity Lutheran Church
1345 Gratiot Avenue
Detroit, MI 48207

Agenda

1) **Welcome and Introductions**.....*Paul Bridgewater*
Executive Director, DAAA

2) **Objectives of Today's Meeting**

- ✓ To learn about the overall MI Detroit concept
- ✓ To form content-specific work groups that will determine the details of MI Detroit
- ✓ To begin discussions within each work group on each content area

3) **MI Detroit: Prepaid Long Term Care Health Plan**.....*David Youngs*
Consultant, DYNS Services, Inc.

4) **MI Detroit Work Groups**

a. Roles and Responsibilities: Develop a Blueprint for MI Detroit
b. Time line: Completed by January 2006
c. Coverage for Medicaid population in Detroit which includes persons with disabilities and the elderly
d. Coordinate with DCH so they can write application based on best thinking from Detroit.
e. Crosswalk with Governor's Long Term Care Task Force

5) **Work group breakout sessions**.....*Work group facilitators*

a. *Self Direction / Consumer Direction*
   - ➢ Exploring person centered planning; consumer direction via the cash and counseling model; and enrollment issues.
   - ➢ Single Point of Entry.

b. *MI Detroit Benefits/Services*
   - Designing the proposed health cooperatives and coordination with adult day services and home health programs;
   - Exploring innovative housing services to be included in the model;
   - Recommending how Department of Human Services (DHS) Adult Home Help would be included in the plan;
   - Determining the MI Choice Waiver services to be included;
   - Considering the role of PACE and nursing facility services;
   - Examining other services and supports to be included.

c. *Quality Management / Improvement*
   - Identifying processes for measuring quality outcomes of the plan, including quality of life, quality of services, customer satisfaction, and clinical outcomes measurement;
   - Determining how the current assessment process could include person centered planning and quality of life domains.

d. *Funding / Finance*
   - Determining the methodology to be used to develop a per member per month rate structure;
   - Identifying the operational and administrative costs for the proposed structure;
   - Determining the number of beneficiaries by year for five years, and the cost per beneficiary group utilizing the tools of risk management, actuarial analysis, and case mix analysis.

6) Workgroup Reports

7) Meeting Schedule/Next Steps

MI Detroit - *A New Long Term Care Prepaid Health Plan*

Welcome to the MI Detroit Planning Process!!!

The Detroit Area Agency on Aging (DAAA), as convener, is proposing to develop a new and exciting prepaid long term care health plan called MI Detroit. MI Detroit will build on the success of community agencies to create a new and potent response to Detroit's health crisis. As first outlined in the "Dying Before Their Time" Study produced by the DAAA, a new immediate response is called for to provide Detroiters with a viable service system within their own community. For years, funds for nursing level care have left the city as nursing homes close and funds are allocated elsewhere; MI Detroit will end this erosion, and you have been invited to participate in this project.

It is the intent of the DAAA to lead a local visioning process to design a coordinated model of long term care (LTC) within a managed care, or a prepaid health plan, framework. DAAA intends to maximize community supports so that residents may receive LTC in their setting of choice. Local community leaders have formed a steering committee and will look to experts for thoughtful and careful study in the design of a new LTC system in Detroit.

Experts are asked to join into four major workgroups to assist in building the system adhering to the principles of current federal and state LTC reform initiatives. The overarching goal of the workgroups is to design blueprints of key components of a LTC health plan to serve as the model for a new federal waiver to be pioneered in the DAAA service area. This model will blend current federal and state reform initiatives that will meet local LTC needs.

In addition to your expertise in your subject matter area, all participants in the MI Detroit planning process must be familiar with the following key source documents:

- Detroit Area Community Health System Concept Paper
- MI Detroit PowerPoint
- MI Choice Waiver
- Recommendations of the Governor's Long Term Care Task Force

Work Group Template: Please use the following template to aid you in planning and developing your project report. For each of the four workgroups, we have provided a definition as well as an outline of the major components of the work group reports. This is a flexible template!! We want ideas and creative thought. In the end we can cut and paste to make the workgroups report fit into the final report.

Ground rules:

- All groups are ad hoc, these groups meet at the pleasure of the chairperson and will end once the concept paper is completed
- Groups may invite any subject matter experts they feel will be useful in developing recommendations.
- Groups representing adults with disabilities and those aged 65 years and older in need of long term care (LTC) will be equally represented
- Consumers will be invited to participate in the deliberations.
- Groups will appoint a scribe and provide written reports of all activities, and for each task force meeting
- Roberts Rules and common courtesy will be used to conduct meetings

Work Groups:

1) Self Determination for People with LTC Needs: MI Detroit will develop services for people in a person focused, self directed model. Where possible participants in MI Detroit will be in charge of ordering and managing services provided by the Plan with the support and counsel of professional staff.
    a. Background/Key Concepts:
        i. Money Follows the Person
        ii. Cash and Counseling/ Self Determination
        iii. Single Point of Entry
        iv. Person Centered Planning
        v. Supports Coordination
    b. Outputs:
        vi. A Single Point of Entry blueprint that includes a comprehensive array of services and supports and the necessary infrastructure to manage the program.
        vii. A designed and demonstrated Person Centered Planning model customized for use with the LTC population.
        viii. A designed and demonstrated Supports Coordination program customized to meet the needs of the local LTC population.
2) **Benefits/Services:** MI Detroit will provide a unique and effective blend of long term care health and housing services designed to help participants maintain community living in the milieu of their choice. The thirteen MI Choice wavier services will be blended with other similar services, such as Adult Home Help, and new services to provide a cost effective array of services for persons with disabilities and the elderly.
    a. Background/Key Concepts
        i. Nursing facility
        ii. Level of care
        iii. Community Health Cooperatives

iv. Adult day services
v. Home Health and Personal Care
vi. Housing
vii. MI Choice Waiver
viii. Other

b. Outputs:
i. A blueprint of comprehensive benefits services and supports that address the needs and preferences of the LTC population.
ii. Defined standards for new services and revamped existing standards of community based services for a meaningful and manageable plan to be implemented in partnership with consumers and clinicians.
iii. A transition and training strategy to evolve current care management practices into a supports coordination program.

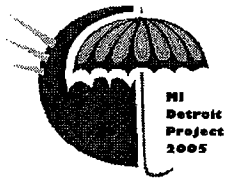
3) **Quality Management/Improvement:** In almost every health care sector, initiatives are underway to develop and improve quality measures for care and participant satisfaction. This is especially true for home and community services. Unlike the standards developed around the nursing facility and home health industries, using the Minimum Data Set Resident Assessment Instrument (MDS RAI) and the Outcomes Assessment Information Set (OASIS), the process of development of national standards for home and community based programs is in its infancy. The process to develop these standards may require considerable effort and expense as new and innovative quality processes are developed which build on the MDS and OASIS, yet address the unique and emerging needs of community based care systems. MI Detroit will embrace and enhance the emerging quality systems for home and community based services while meeting the unique requirements of the area.

a. Background/Key Concepts
i. Quality of Life
ii. Quality of Services
iii. Customer Satisfaction
iv. Outcomes Measurement

b. Outputs
v. A blueprint of a comprehensive quality initiative that measures participant satisfaction with the program and its services and workers, Quality Assurance and Quality of Life (CIM & Brant)
vi. A Quality Assurance plan

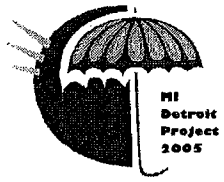
vii. Tools and protocols for use of MDS Quality Indicators, QA and participant satisfaction programs.

4) **Funding/Finance:** The goal will be to develop a cost model for the MI Detroit long term care health plan. The system will be based on a case mix reimbursement system using the RUGS III methodology. The task for will identify potential service groups, benefits packages costs and develop a risk based model for financing the MI Detroit plan. This will include
   a. Background/Key Concepts:
      i. Local funding to enhance Medicaid funds
      ii. Risk Management
      iii. Actuarial analysis
      iv. Case Mix analysis (acuity based service reimbursement)
      v. Information systems/MICIS
   b. Outputs:
      i. A comprehensive blue print that demonstrates a funding scheme and possible rate structure integrating federal and state LTC resources with new local funds that support a prepaid LTC health plan.
      ii. A "best practice" document based upon research of other states LTC systems.



Governor's Long Term Care Task Force And MI Detroit Crosswalk

	LTC Task Force	MI Detroit
1	Require and implement person-centered planning practices throughout the LTC continuum and honor the individual's preferences, choices, and abilities.	Plan is based on principles of self determination and person centered planning practices for persons with disabilities and frail elderly. A planning work group is charge with developing this aspect of the plan.
2	Improve access by establishing money follows the person principles that allow individuals to determine, through an informed choice process, where and how their long term care benefits will be used.	Personal choice and money follows the person are key principles to MI Detroit. Participants will choose where and how long term care benefits will be provided in Detroit. Funds will be allocated monthly to service choice of participant.
3	Designate locally or regionally-based "Single Point of Entry" (SPE) agencies for consumers of long-term care and mandate that applicants for Medicaid funded long term care go through the SPE to apply for services.	MI Detroit includes plans to establish a single point of entry as well as universal information and referral system using a web based technology developed by ServicePoint and already in use for Homeless Management Information System.
4	Strengthen the array of LTC services and supports by removing limits on the settings served by MiChoice waiver services and expanding the list of funded services	Proposes to expand LTC services and supports by enhancing array of service to include MI Choice, Adult Home Help, Nursing Facilities, Housing and Assisted Living, Adult Day Services and PACE to develop supports to keep people in their homes and communities.
5	Support, implement, and sustain prevention activities through (1) community health principles, (2) caregiver support, and (3) injury control, chronic care management and palliative care programs that enhance the quality of life, provide person-centered outcomes, and delay or prevent entry into the LTC system.	Plan develops community health cooperatives to provide comprehensive community health services built around existing provider network of home health and adult day services. Acute and chronic care providers will also be included in the cooperatives. The focus is to rebuild shattered community health systems.



6	Promote meaningful consumer participation and education in the LTC system by establishing a LTC commission and informing the public about the available array of long-term care options.	Plan creates a MI Detroit consumer commission to advise and inform.
7	Establish a new Quality Management System for all LTC programs that includes a consumer advocate and a Long Term Care Administration that would be responsible for the coordination of policy and practice of long-term care.	Establishes comprehensive quality management program including a critical incident management system and a quality of life/quality outcomes management process based on the CMS quality framework.
8	Build and sustain culturally competent, highly valued, competitively compensated and knowledgeable long term care workforce teams that provide high quality care within a supportive environment and are responsive to consumer needs and choices.	Development of a quality workforce, knowledgeable in the needs and requirements of Detroit and statewide efforts will produce enhanced services and supports for participants.
9	Adapt financing structures that maximize resources, promote consumer incentives, and decrease fraud.	Plan will build on the quality financial structure in place at the Detroit Area Agency on Aging providing independent audits, consumer fraud tracking and other financial services required to promote financial integrity.

Myers, Roger

From: Ruth Kaleniecki [kalenieckir@DAAA1A.ORG]
Sent: Friday, July 08, 2005 9:48 AM
To: Myers, Roger
Subject: MI Detroit Benefits and Services Workgroup

Compiled
ommendations.doc

Mr. Myers,

Earlene Traylor Neal asked that I email you to see if there is anything that you would like to contribute to the Benefits and Services portion of the MI Detroit Project. We are working on compiling our final recommendations in preparation for writing our final report. Attached, you will find the recommendations as they now stand.

Thank you.

Ruth

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MI Detroit
Benefits and Services Workgroup
Final Recommendations
DRAFT

Starting Points:

- The City could be divided into districts or neighborhoods. Services should be neighborhood driven (geographically driven); services should be provided in a person's neighborhood. This would be helpful for quality assurance purposes.
- The project needs to save the state money while also providing preventative services. There should be an incentive for doctors, etc. to serve in a particular area as neighborhood physicians.
- Need to be aware of intergenerational support and conflict. In most cases, families are involved, so the "person" may be more than just the client. Our system needs to be able to address the issue of family involvement.
- There always needs to be someone who is able to advocate for and insure that the person has access to all of the services that they need → Supports Coordinator
    - Supports Coordinators need to be mindful that people are entitled to get a pair of diabetic shoes each year through Medicare so that they can assist clients in obtaining them. This kind of presentation of information and access to resources should be part of a comprehensive assessment.

1. Would all MI Choice Waiver services be included or modified?

- Yes, all Waiver services should be included.
    - Adult Day Health
    - Chore Services
    - Counseling Services
    - Environmental Accessibility Adaptations
    - Home Delivered Meals
    - Homemaking
    - In-Home Respite Care
    - Out-of-Home Respite Care
    - Personal Emergency Response System
    - Personal Care Waiver
    - Private Duty Nursing
    - Specialized Medical Equipment and Supplies
    - Training
    - Transportation
- Look at the level of demand in relation to the amount of services available so that Medicaid dollars can be guided toward those services that are in demand. (Demand is driven by quality and accessibility of services, not just availability of services.)
- Might need to look at reconfiguring/bundling existing services. Consumers do not view assistance as discrete services.
- Create a resource booklet so that consumers know what is available to them and distribute the directory within the community.

- Even with person-centered planning, we should look at a hierarchy of needs:
    1. Medical needs
    2. Basic Needs – Health, safety and welfare
    3. Personal and recreational needs
- Remember person-centered planning. Prioritizing is important, but what the client says is #1 needs to be seriously considered.
- Need to have guidelines, or the money will be diverted all over without the basic needs being met. Must prioritize for basic health and well being; must still have some gatekeeping responsibilities.
- Meetings could be held at Neighborhood City Halls to determine the needs within each neighborhood, recognizing that different communities have different needs.
- Assistive technology for the disabled should also be included as a benefit.
- MI Choice Waiver Services need to be expanded to include the following:
    - Comprehensive transportation services
    - NFTI
    - Medication Management

(School administrations need to enforce the requirement for all Detroit area students to earn 200 hours community service. The students can do things like assist seniors in their homes with organizing their cabinets so that they can reach everything that they need. This way, the students would be interacting with the seniors and helping them, and would not be taking skilled work away from the providers.)

2. How would DHS Adult Home Help be included in the plan? Would we develop combined intake and assessment for DHS Adult Home Health Participants?

- Yes, this program should be included in MI Detroit because seniors and the disabled are independent people and should have as much choice as possible.
- Under the Adult Home Help program, the client selects a person to be their "chore worker."
- There should be simply one chore service and enrollees can choose either an individual "chore worker" or an organization that provides chore services.
- This choice of provider would apply to other services, personal care, homemaking and chore services.
- Need to maintain a quality assurance mechanism to prevent abuse of the system.
- Rates for Adult Home Help should be adjusted to be comparable with other chore provider agencies.
- Background information about the DHS and Waiver Programs.
    - Currently, if a person wants Adult Home Health Care, they either choose to go through DHS or DAAA. It would be nice if we could combine the processes and share information and resources and make sure that clients are aware of all of the services that are potentially available to them.
    - The Adult Home Health Grant through DHS does not offer as many services as the Waiver.
        - You cannot get respite (in or out of home) or adult day care with the DHS Adult Home Health Grant.

    - DHS Adult Home Health rate of pay for providers is less than that which is provided for by the Waiver.
        - The worker at DHS decides how much is going to be paid for services.
    - The DHS and DAAA programs cannot be fully merged because they are distinct.
        - It would be nice if the Home Health Grant could be managed by the DAAA so that people can have one more choice in services.
    - Currently, DHS will decide what services will be offered after receiving input and recommendations from the client's physician.
        - The Adult Home Health Grant could be more accessible if provided through DAAA.
- The workgroup's recommendation is that the Adult Home Health Grant be offered as another option for clients and therefore be offered through the DAAA.
    - If we combine the services, we will be able to be a motivating force for DHS to improve their services because the services that are offered by DHS currently are not easily accessible.

3. What would the proposed health cooperative look like, and how are they defined? How would they coordinate with adult day services and Home health programs?

- There could be satellite DAAA offices within each district, with a DHS worker to determine eligibility, and DAAA staff providing access to health, informational and directional services available in each neighborhood.
- How formal is this "cooperative?" The group decided the term refers to an organized cooperation of services under the auspices of DAAA, rather than an organizational structure.
- The model should not take anything away from those that currently control the money. There can be problems with fiduciary responsibilities because people "get touchy" if others take control of the funding.

Proposed Health Cooperatives and how they would coordinate with adult day services and home health programs:

- The supports coordinators will be housed at the health cooperatives and will be vital linkage between the cooperatives, adult day services, home health, programs, and clients
- Health care cooperatives are satellites and provide the person with the information that they need in order to make educated choices, related to the brokering of their available dollars.
- Coop where all recipients of care share buying power for contracts for services?
    - To what degree can we aggregate the buying power?
        - What does it mean to aggregate the buying power? What would be the benefit of having an aggregate buying power? Would there be a bidding process?
            - People will have different needs and so there might not be a benefit to aggregate buying power. There are too many individuals who have unique circumstances to really be able to aggregate the buying power.
            - The idea of "aggregate buying power" came from the discussion of what it means to have a "Cooperative." Either the co-op would be informal, or it would be a set-up through which clients who are members of the co-op are able to pull their resources, i.e. aggregate their buying power, and

determine which service providers are going to be able to provide services within the co-op.
    - Allows input into the administration and the decision-making.
    - Consumers influence the type of services.
- Open membership.
- Focus on individual needs through person centered planning.

4. Would PACE be included in the health cooperatives?
    - Yes, it should be included in the MI Detroit model.
    - PACE (Program for All-inclusive Care of the Elderly) is funded through a Medicaid waiver, along with Medicare funds. Henry Ford operates the program, (called the Center for Senior Independence); Boulevard Temple is also in the process of applying to house a PACE site.
    - PACE is similar to a "day nursing home."
    - PACE Program offers an array of services which gives clients an alternative to a nursing home based on individual needs
    - Persons in the PACE program do not need to attend CSI on a weekly basis in order to be a part of the program.
        - Once clients are in the program, they can move to an assisted living facility or nursing home if they need the services that those facilities offer.
    - There are currently 33 PACE sites in the country. PACE has been functioning for 35 years.
    - The development of PACE sites is very difficult and very expensive.
    - There are thousands of people in the Metro-Detroit Area who could benefit from PACE, so there is certainly room for more PACE sites.
    - CSI enrollment will be capped at 230 people in October. Enrollment is currently 193 people.
        - The CSI facility cannot accommodate more than that.
        - States (including Michigan) have been reluctant to expand the PACE program.
    - CSI will be happy to be involved in whatever MI Detroit offers, but we must be mindful that there are very limited slots for enrollment.
    - CSI budget is $11M per year. There really needs to be a strong financial backer for PACE sites. CSI is supported by Henry Ford Health Systems. Breaking even is the goal for this year.
    - PACE sites cannot cherry pick enrollees; they just have to accept all those who qualify.
    - If we are not able to create a new PACE site, the next best thing is to expand the Waiver.
    - Some of the PACE services are offered by other agencies, but PACE cannot be replicated by other agencies, because PACE covers everything.
        - PACE provides all needed care and services until the client dies.
        - PACE will offer and provide nursing home and hospice care as needed.
    - CSI is looking to expand. There are needs that are not being met in the City. There are 5,000 people in Metro-Detroit who could benefit from PACE.
    - Grand Rapids is developing a PACE site.
    - PACE just makes sense.

5. What innovative housing services would be included to help people live in the community? Examples include housing counselors, services to persons in a variety of housing with services living arrangements, Home repairs, telemedicine and Home based medical technology?

- There needs to be an inventory of properties (assisted livings, nursing homes, etc.) so that we have a current listing of the available facilities. A person's choice may be to remain in the City if new housing concepts were available.
- Need to create a collaborative partnership of providers of housing.
  - MSHDA should be included in our discussion, along with other public housing officials.
  - Definitely need input from the disabled community regarding housing options and preferences.
- Section 8 Vouchers: 30% of income is for housing costs and a federal subsidy pays the balance.
  - Similar to what's allowed at the state level in MI Choice, provisions for first month's rent, furniture and past due utilities should be included in MI Detroit.
  - Public housing can add to their plan an allocation of vouchers to this program as a priority.
- Need to look at the creation of new models of supportive housing, and incentives for new developments.
- Could bring housing facilities in as service providers (for homemaking, chore, etc.) to residents in their buildings.
- Home repair is critical. Without it, there is no way to control the home environment.
- Younger disabled persons often prefer not to live with seniors. However, clustered, yet independent community supportive housing would still save on staffing costs because the people are living together.
- MI Choice program offers less intensive services, however, the attraction to the program is that the participants do not have to leave their home to receive any of the services rendered. The assessors, nurses, caregivers, and meals on wheels are delivered to their homes directly.
- Seniors are reluctant to leave their homes for services because they do not want to lose their income.
- Care must be given in a way that the seniors do not feel violated. Caregivers must perform their jobs with dignity.

Suggestions from Sue Eby:

1. Supports Coordinators with the role of helping people find, obtain, and maintain housing for both rental and homeownership.
2. Building community collaborative role for the purpose of increased funding of and access to safe, accessible, affordable house and services.
3. Training for supports coordinators in services and housing.
4. Home repairs (accessibility and health and safety repairs) and/or raising the asset limit to $10,000 for Medicaid programs (so that people have some money on hand when the housing needs repair or for other emergencies).
5. Rent and mortgage supplements up to 1 year so that home can be maintained during hospitalization and nursing facility stays.

6. Assistive technology (includes medical technology that can help the person live independently)
7. Transition resources, which include housing applications; deposits; payment of past due utility bills or other bills which keep a person from obtaining housing; basic furniture; appliances; moving expenses; one-time cleaning expenses (upper limit should be established)

Other thoughts about how to increase the housing options for this population:

- Ask public housing authorities to make this population a priority for their Section 8s (Housing Choice Vouchers), including setting aside some tenant and project based Section 8s and other resources to increase the number of affordable and accessible units. Encourage collaboration between the Public Housing Authorities (and other providers of low income housing options) and Service Providers to increase the likelihood that people can live in the community.
- Advocacy to increase the HUD budget for this year, including contacting Representative Knollenberg (202-225-5802) who chairs the subcommittee of U.S. House of Representatives Appropriations.
- Cross-train the MI Detroit Stakeholder group on innovative housing plus service options, such as Suportive Housing (everybody chooses their own apartment or home and a supports coordinator is available on a 24-7 basis).

6. How would nursing facility services be included in the plan?

- Part of the deterioration of the long term care health system is the decay of our current nursing homes. Want to work with nursing facilities so that they will evolve along with other long term care providers into the MI Detroit Person Centered approach. Idea is to help the system work better for the people.
- The ideal nursing home would be a single story on 4 acres with each room having a nice view. An assisted living facility could be attached or detached, with adult day care services available. Property could be made available for other developments such as faith based services.
    - 100 skilled beds providing quality services.
        - Less than 100 beds is easy to administer and easy for staff.
    - Short term 45-90-120 days, right out of the hospital.
    - Care after Medicare runs out is the issue.
    - Should be in the neighborhoods; could convert schools.
    - 50-60 bed homes profit only with many short stays; but falls turn into long stays with the onset of confusion and pneumonia.
- It was noted that perhaps we need not focus on what the "perfect nursing home" is. We need to focus on the services being offered, rather than the way that the nursing homes look.
    - The nursing homes should include whatever services are currently included by a skilled Medicare/Medicaid nursing home.
        - Focus is on care.
        - Activities should be offered so that residents have options about how to spend their day. Outings, computers, and libraries should be made

available. Try to make the environment as home-like as possible. Also, children and animals should be encouraged to visit the facilities.
        - Person-centered care needs to be a focus, so that people have a say in the care they receive. (E.g. People should have the option to decide when they want to get up, eat, go to bed, etc.)
        - We need to think about the preferences of the individual, rather than just the schedule of the facility.
    - Give nursing assistants (Aides/C.N.A's) a say in the care that is provided.
        - Staff will be able to be better retained.
        - Care will be better because C.N.A.'s will feel better about the work that they are doing.
        - C.N.A.'s should be required to receive continuing education.
        - Aides try to do their best, for the most part.
        - Aides need to know what the condition of the residents in their care is so that they can provide care accordingly. This will also empower the aides and help them to feel better about the work that they do.
    - Smaller nursing homes (less than 100 beds) would be ideal because they will be better able to provide the care that is needed and the staff will know the individual residents and their needs.
    - Ideally, we would use the Green House philosophy to create homes for 10-12 people.
        - There are only two Green House sites currently in the nation.
        - Green Houses need to be built in conjunction with existing nursing homes.
        - Green Houses are run quite differently from current nursing homes.
            - Aides are expected to perform different kinds of jobs than they would if they were just working in a nursing home. This required special agreements with unions.
        - Residents of Green Houses have responded very positively. Many have made quick and significant improvements because of being moved to the more home-like environment.
    - Nursing homes need to have strict guidelines to prevent overmedication of residents.
        - Overmedication is illegal.
        - Residents of nursing homes who have legal guardians or do not have supportive families are more susceptible to be overmedicated because it is less likely that there is someone who is vigilant in advocating for the resident.
    - C.N.A.'s need to be more supported, better paid, and respected because they provide most of the care in facilities and are the most direct line to the resident.
        - The facilities that offer better wages have a lower turn-over and the care provided to residents tends to be better.
    - High turn-over could be the result of many factors, including poor management, the environment, the wage offered, the location of the facility.
        - Facilities that are independently owned and operated seem to not have as many problems as the larger chains.
- Nursing Home Services

- New kinds of activities – active, not passive
  - Cooking classes
  - Outings
- Physical and occupational therapies
  - According to Medicare guideline, residents can only stay on Medicare therapy services if they are participating in therapy and are showing improvements.
  - Residents need to be part of the determination of their schedule so that they are more likely to participate.
- Involvement of families
  - Family Council
    - Have monthly meetings
    - Allows people to vent their complaints and to form relationships with other family members
    - Guardians and friends should be allowed to attend (Council of people who care about the well-being of the resident.)
- Nursing Homes should have relationships with the communities.
  - People need to have options, though, so we need to be careful not to impose services on residents that they do not want.
  - Do not lose the voice of the person in making decisions. "If they can think for themselves, My Lord, let them think for themselves!" (Christine Hawkins – reflecting upon her personal experiences.)
    - Residents who are involved in decision-making will be happier which will mean that they will be complaining less and will also likely need less medication.
- What does it mean to be person-centered in the facility?
  - Resident Council – Residents in facilities have some debility, so they need to be led by a good staff person (May be the activity director)
  - Staff members need to care. People need to be screened to make sure that they have a "caring heart" before they are even hired for the position. How do we do this?
    - Staff eat the same food that the residents are served.
    - Asking the same question many times during the interview can be a test of whether or not staff will become irritated with residents who have cognitive impairment.
    - Screen for people who are respectful and have a caring attitude.
    - Have folks who are interviewing for positions walk through the facility during their interview so that they can be observed interacting with residents.
  - We should discover the best practices of facilities in the area and attempt to operationalize what local facilities are already doing well.
    - Good hiring practices
    - Person-centered care
- It is wonderful to hire people with a good heart, but we need to keep their heart alive and feeling.

        - Provide incentives and a sense of ownership to encourage people to work harder.
            - Employee of the week
            - Give staff a clear sense of the vision and mission of the facility that they can buy into.
            - There is nothing that is concretely tangible, but there is something about the culture of the facility that will help people to feel invested in it.
        - C.N.A.'s need to be included in the meetings in which decision are made, because they know what is going on with individual residents and their families.
            - Provide opportunities for staff to submit ideas to change the operation of the facility.
            - The EDEN alternative lays out ideas about how to engage staff on all levels.
            - Green Houses, because they are home-like, offer the opportunity for staff to sit down and actually visit with residents, which allows them to feel better about the work that they do and also enhances the well-being of the residents because they are engaged in meaningful interaction.
- Green House
    - Staff are better paid ($4.00 more an hour)
    - Duties are collapsed for aides (meaning that the aides have more duties to fulfill), but there are less people to provide care for.
    - The residents live in independent rooms with their own bathrooms.
- Creation of a nursing home in the middle of an independence village. This allows people to stay in their neighborhoods.
    - The older you get, the less you want to move.
    - Allow for "aging in place."

7. How would health education, disease management, health promotion and prevention services be included throughout the program at each level of care?

- Prevention is heading off an illness before it occurs. At some point, engage individuals in the psychology of their emotions and improvements in their health. This would save money in terms of creating
    - Person centered services model.
    - Single point of entry.
- Prevention – reaching individuals before the problems occur, in terms of what can be done to prevent the diseases/ crises. Emphasizing diet, exercise, and keeping the mind active. Keeping people informed through their churches.
- Patients currently rely on instructions from the hospital discharge planner, which is not sufficient because the discharge planner, in most cases, does not know the patient or his or her situation with any level of certainty.
- Develop a tracking system for individuals.

    - Assign a support coordinator to each patient to determine what type of service is needed. Upon the patient's discharge from a hospital, the support coordinator, with input from the patient and his/her family will determine where the patient will be sent – nursing home, adult care center or what level of home care is needed.
        - With money following the patient, a cafeteria of services are offered to the patient upon his/her discharge from the hospital and the supports coordinator will help the patient to select those services which will most appropriately meet his or her needs.
    - This tracking system will also trigger the necessary providers to get in touch with the individuals whether they are at home or being discharged from a hospital.
    - Once a patient gets into the health care system, the support coordinator will have the responsibility of checking on the patient's progress.
    - Satellite district offices will be set up with the tracking system.
- Health education must also be shared with family, significant other, or patient representative, or guardian; the institution that provides the assistance cannot do it without the appointed designee.
    - Keep in mind that not everyone has access to the Internet and therefore some need to receive information from more traditional mechanisms.
- Create a mandatory in-services requirement for caregivers and family members to acquire information, which can be provided in the homes, churches or neighborhood satellite offices. The training will enhance their own personal growth and health through healthy aging / healthy living. This education can be made mandatory for those family members who would like to be paid caregivers of consumers. The training and in-services could be requirements for their reimbursement.
    - Caregivers must be trained, certified, and bonded.
    - Families must be diligent about the quality of services that they are providing to consumers, because the services that are provided to consumers through MI Detroit must be as good as the services that the consumer would receive in an institutional setting.
    - Offer educational programming that has multiple modules – professional, individual, family, caregivers – where all those who participate will be receiving similar messages and getting information from various sources, but with levels of specificity that are appropriate for the audience. Source information needs to be consistent throughout the modules.
- The workshops, individual tracking system, training for the support coordinators (all coordinators must have the same initial training), setting up the satellite service centers with trained community service workers should all be coordinated through the network of Detroit Area Agency on Aging.
- Provide information to the families through outreach services via: television, the media, and an organization such as DAAA.
- Partner with other organizations committed to dealing with chronic diseases.
- Partner with faith based organizations (e.g. the Healing Zone)
- Utilize a "Healthy Moment" concept. The Healthy Moment concept is one in which community groups will be encouraged to share a health promotion message with group

members at the conclusion of their meetings. This way, people will have more exposure to simple things that they can do to promote health and wellness in their own lives.

- Systems change. The holistic approach and health promotions education needs to permeate every conversation between the client, support coordinator, and service provider so that when factors within the systems change, steps can be taken to promote other resources.
- At the senior apartments and public housing units where Food and Friendship congregate meal sites are located, provide educational training in respite care, outreach, and skilled home care.
- Create a 800 hot line number so that consumers, their caregivers, and providers have access to health information at all times.
- Supplying pedometers to seniors to track their daily / weekly steps.
- Emphasize the correlation between fun and health i.e., dancing.
- We cannot allow people to feel defeated by their illness.
- We can provide hope to people through education and training.
- Wellness initiatives need to be included throughout the continuum.

8. What other services and supports would be included?
    - Transportation is a major barrier. At minimum, people need to get to their physicians if we are to have even the smallest impact on health. Transportation is a fundamental right needed for all to enjoy a less restrictive life. Need to go grocery shopping, etc., too – not just to the doctor's office.
    - Mental Health Services
        - Persons with mental illness need to be able to have a voice in the selection of their providers.
        - Persons with mental illness need to be able to receive the services that they need within in the community. They should not be segregated from the general population.
        - When persons with mental illness need to be in facilities, they should be placed in facilities that are specifically for those persons with mental illness, or at minimum, be placed in facilities where staff have specific training in working with persons with mental illness.
        - Care providers need to rule out the physical before assuming that a person's problem is mental.
    - Persons with substance abuse problems should be placed in special facilities with the kinds of specialized services that substance abusers need.
        - We need to make sure that we are functioning within the law if we are to create different facilities for different groups of people.
        - Perhaps we should develop facilities with different units so that we can best meet the needs of each group of potential clients.
    - Work Program
        - As part of comprehensive assessment, collect job skills information so that people can be linked to businesses in the City and work as they are able.
        - Provide mentorship opportunities.
            - Sick and shut-in ministries through the churches.

    - Persons need a purpose.
    - People need to receive services that make them feel better about themselves such as having their hair done, nails painted, sharing a meal with someone, or having their skin lotioned.
- People will access the services either through providers that they already have relationship with or through the single point of entry.
- One of the other workgroups will be addressing the single point of entry structure.

MI Detroit:
Self Directed
Managed Long Term Care

Presented by: The **Detroit Area Agency on Aging**

Prepared by DYNS Services, Inc.

June 2005

What is MI Detroit?

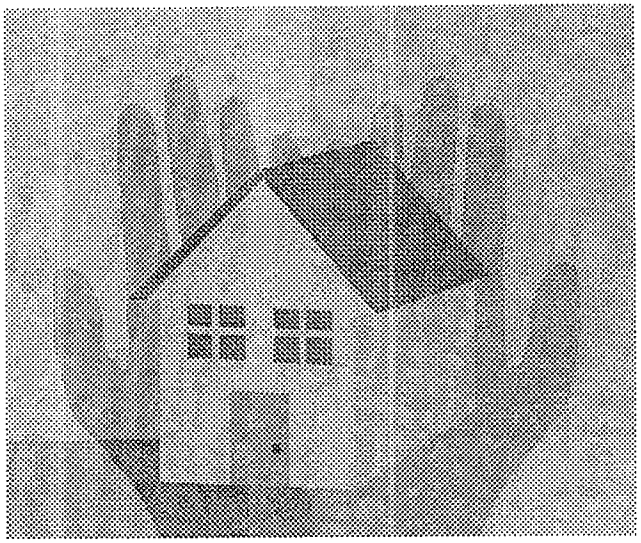
- A coordinated model of long term care (LTC) health service delivery
- Provides services using a prepaid, managed care model
- Incorporates Governor's LTC Task Force values and goals
- Designed to avoid unnecessary institutionalization and maximize community living and supports

MI Detroit Services

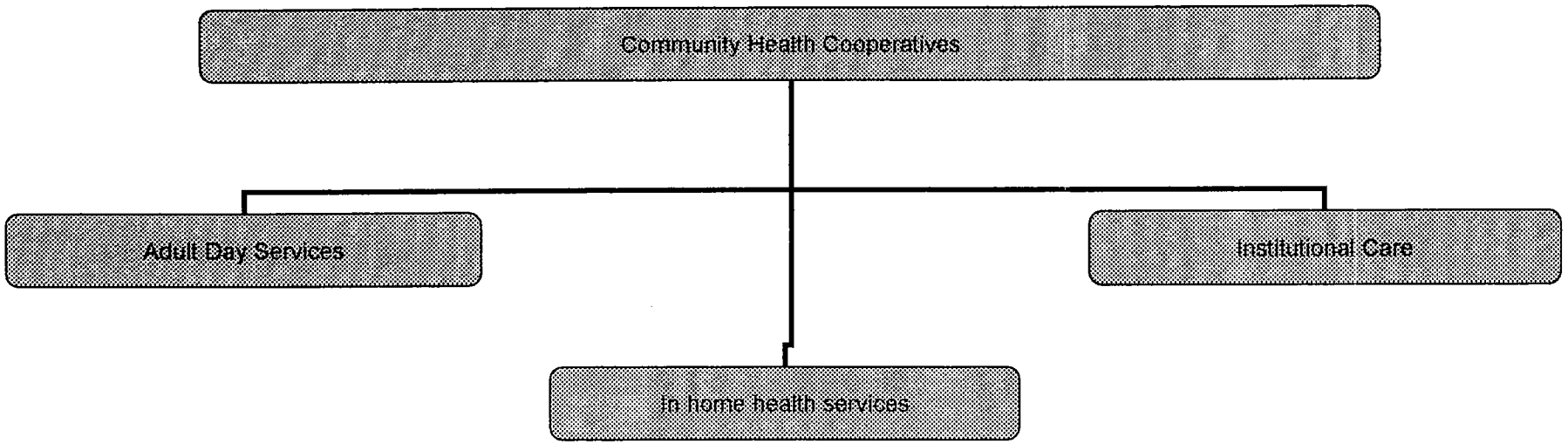
- MI Choice Waiver
- FIA Home Help
- Medicaid long term care (including nursing facilities)
- Physical Disability Services
- Supportive housing & Assisted living
- Universal assessment and screening
- Information & Assistance
- Supports Coordination/Care Management

MI Detroit Structure

- 1915 (b) (c) Medicaid Waiver
- Part b will provide managed care (cost capitation) either voluntary or mandatory
- Part c provides community based services
- Home Help &Housing
- Community Health Cooperatives



Health Coop Components



Who will participate?

- Detroit area residents who need long term care medical services, including:
  - Adults with disabilities
  - Elderly
  - Persons at risk of institutionalization in community and acute care settings

Key Features - merges reform and new directions in care management

- Self directed care initiatives including *Person Centered Planning & Cash and Counseling;* participants take an active role in planning and managing their services and providers
- Money follows the person to the location chosen by participant (e.g. Home Care, Assisted Living, Supportive Housing and Nursing facility)
- Greater control and honoring preferences = improved *Quality of Life*

Key features, continued

- *Single Point of Entry*; all things to all people in regard to long term care information & services
- Case mix adjusted rates: rates based on health service requirements
- Housing options: supports for existing participant homes and development of new options such as assisted living and supportive housing
- Critical incident management system

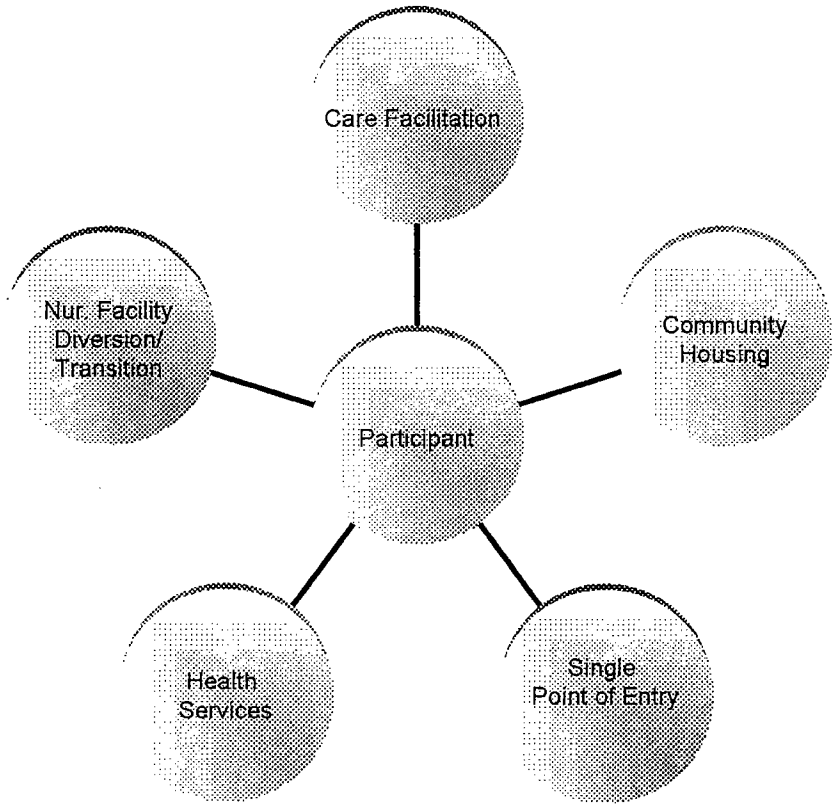
Supports Coordination & Financial Intermediary

- Care management evolves to supports coordination by empowering participants to direct their own care
- Participants may hire the provider and/or worker of their choice to meet service needs according to their preferences
- A financial intermediary will be utilized to pay providers from authorized service plans
- A financial intermediary will provide utilization reports

Why do we need this?

- 18,000 excess deaths per year
- Lack access to health care
- Deaths due to preventable chronic diseases such as hypertension, diabetes and heart disease
- Lack of appropriate service: 66% of elderly who need health services, do not receive them
- Caregiver burnout: lack of services leads to more reliance on caregivers, average over 30 hours per week.

MI Detroit Model



Who?

- Community and State Representatives concerned about LTC in Detroit:
  - Detroit Area Agency on Aging
  - Participants and advocates
  - Service Providers & Nursing Facilities
  - Michigan Department of Community Health
  - Center for Medicare & Medicaid Services
  - Detroit Health Authority
  - Open to other groups

What?

- Develop a detailed plan for MI Detroit including
  - Vision statement
  - Goals
  - Plan including tasks and resource allocation (people, money and time)
  - Gain stakeholder support and cooperation
  - Interface with Governor's LTC Task Force and federal initiatives

When?

- MI Detroit project will begin now with scheduled completion on January 1, 2006
- Draft plan completed by August 1, 2005
- Complete required waiver amendments/applications September 1, 2005
- Estimated 5 months for approval from CMS

Where?

- Plan will include proposed coverage area, possibilities include:
  - Wayne County
  - City of Detroit
  - Demonstration areas in sections of service area

How?

- Form a MI Detroit Strategic Planning Task Force (local leadership)
- Collect and analyze data: services costs, acuity levels, demographics, etc.
- Form work groups comprised of subject matter experts to look at service packages, risk management and cost projections
- Draft and publish final plan for MI Detroit
- Implement plan

Work Groups

- Self Determination/consumer direction
- Benefits/Services
- Quality Management/Improvement
- Funding/Finance
- Steering Committee

Work Groups Role:

- Develop Blueprint for MI Detroit
- Include input from stakeholders including:
  - Consumers
  - Advocates
  - Providers
  - Community leaders
  - Other interested entities
- 3 or 4 meetings
- Final report by August 1, 2005

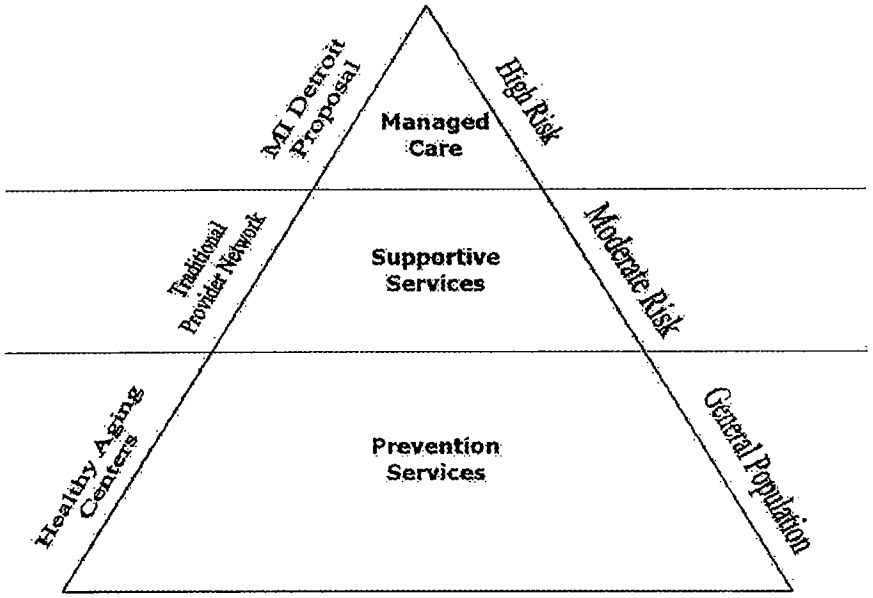
Detroit Area Agency on Aging Role

- Convene MI Detroit work groups
- Single point of entry
- Managed care entity
- Could be both entities

Detroit Area Agency on Aging

A service model to promote healthy aging and enhance the quality of life for older persons and persons with disabilities.

SERVICES MODEL



June 2005

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MI DETROIT Quality Management/Improvement Membership

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Detroit Area Agency on Aging
MI Detroit
Stakeholder Meeting

WORK GROUP DISCUSSION QUESTIONS

A. *Self Direction/consumer direction:*

1. How would person centered planning be included in the current MI Choice assessment and care planning model? How could this be improved/modified for MI Detroit?

2. How could the service model be developed to promote consumer direction via cash and counseling model?

3. How can a critical incident system be incorporated into the service model?

4. How will people enroll in the plan?

5. Will enrollment be voluntary?

B. *MI Detroit Benefits/Services:*

1. Would all MI Choice Waiver services be included or modified?

2. How would Department of Human Services (DHS) Adult Home Help be included in the plan? Would we develop combined intake and assessment for DHS Adult Home Health participants?

3. What would the proposed health cooperatives look like, and how is it defined, how would they coordinate with adult day services and home health programs?

4. Would PACE be included in the health cooperatives?

5. What innovative housing services would be included to help people live in the community? Examples include: housing counselors, services to persons in a variety of housing with services living arrangements, home repairs, telemedicine and home based medical technology.

6. How would nursing facility services be included in plan?

7. How would health education, disease management, health promotion and prevention services be included throughout the program at each level of care?

8. What other services and supports would be included?

C. *Quality Management/Improvement:*

1. What process would be used to measure quality outcomes of the plan including:
    a. Quality of life
    b. Quality of services
    c. Customer satisfaction
    d. Clinical Outcomes measurement

2. What would a quality improvement process look like for the plan that uses information in the quality management process?

3. How could the current assessment process include person centered planning and quality of life domains?

D. *Funding/Finance:*

1. What methodology would be used to develop per member per month rate structure?
    a. Nursing Facility Residents
    b. Home Care

2. What will be the operational and administrative costs for proposed structure?

3. What is the project number of beneficiaries by year for five years?

4. What is the project cost per beneficiary group?
    a. Risk management
    b. Actuarial analysis
    c. Case mix analysis

5. What are the requirements for the data and billing computer system?